

UNITED STATES BANKRUPTCY COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

Bankruptcy Case No. 13-53846  
Honorable Thomas J. Tucker  
Chapter 9

**EXHIBIT E (HAP PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN  
OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION  
THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS  
ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S  
CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT;  
AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND  
(B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]**

PART 1 OF 5



**Health Alliance Plan of Michigan**  
**Health Maintenance Organization (HMO) Plan**  
**Summary of Benefits for**  
**CITY OF DETROIT - ACTIVES**

Health Care Services		Coverage	Limitations*
<b>Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:</b>			
Benefit Period:	Calendar Year		
Annual Deductible	\$750 Individual ; \$1,500 Family		
Co-insurance (amount member pays)	20%		
Annual Co-insurance Maximum	\$1,500 Individual ; \$4,500 Family		These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover, penalties, deductibles, and copays.
Annual Out-of-Pocket Maximum	\$6,350 Individual ; \$12,700 Family		These values do not accumulate: Premiums, balance-billed charges, health care this plan doesn't cover, and penalties. All other cost-sharing accumulates.
<b>Preventive Services:</b>			
Preventive Office Visit / Physical Exam	Covered - Deductible does not apply		
Well Baby Office Visit	Covered - Deductible does not apply		
Routine Hearing Exam	Covered - Deductible does not apply		
Routine Eye Exam	Covered - Deductible does not apply		
Immunizations	Covered - Deductible does not apply		
Related Laboratory and Radiology Services	Covered - Deductible does not apply		
Pap Smears and Mammograms	Covered - Deductible does not apply		
<b>Outpatient &amp; Physician Services:</b>			
Personal Care Physician Office Visit	\$25 Copay - Deductible does not apply		
Specialty Physician Office Visit	\$25 Copay - Deductible does not apply		
Gynecology Office Visit	\$25 Copay - Deductible does not apply		
Audiology Office Visit	\$25 Copay - Deductible does not apply		
Eye Exam Office Visit	\$25 Copay - Deductible does not apply		
Allergy Treatment and Injections	Plan Pays 80% after Deductible		
Laboratory and Radiology Services	Plan Pays 80% after Deductible		
Dialysis	Plan Pays 80% after Deductible		
Chemotherapy	Plan Pays 80% after Deductible		
Radiation Therapy	Plan Pays 80% after Deductible		
Outpatient Surgery	Plan Pays 80% after Deductible		
Chiropractic Office Visit and Related Services	Not Covered		
<b>Emergency/Urgent Care:</b>			
Emergency Room Services	\$100 Copay - Deductible does not apply		
Urgent Care Facility Services	\$25 Copay - Deductible does not apply		
Emergency Ambulance Services	Plan Pays 80% after Deductible		Emergency transport only
<b>Inpatient Hospital Services:</b>			
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Plan Pays 80% after Deductible and \$100 Copay		
Bariatric Surgery & Related Services	Plan Pays 80% after Deductible and \$100 Copay		One procedure per lifetime

<b>Maternity Services:</b>	Covered - Deductible does not apply
Initial Prenatal Office Visit	Covered - Deductible does not apply
Subsequent Prenatal Office Visits	\$25 Copay - Deductible does not apply
Postnatal Office Visits	Plan Pays 80% after Deductible and \$100 Copay
Labor, Delivery and Newborn Care	
<b>Mental Health:</b>	
Inpatient Services	Plan Pays 80% after Deductible and \$100 Copay \$25 Copay - Deductible does not apply
Outpatient Services	Plan Pays 80% after Deductible and \$100 Copay \$25 Copay - Deductible does not apply
<b>Chemical Dependency:</b>	
Inpatient Services	Plan Pays 80% after Deductible
Outpatient Services	Plan Pays 80% after Deductible
<b>Other Services:</b>	
Home Health Care	Plan Pays 80% after Deductible
Hospice Care	Plan Pays 80% after Deductible
Skilled Nursing Care	Plan Pays 80% after Deductible
Durable Medical Equipment; Prosthetic & Orthotics	Plan Pays 80% after Deductible
Hearing Aid Hardware	Plan Pays 80% after Deductible
Vision Hardware	Not Covered
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Plan Pays 80% after Deductible
Voluntary Sterilizations	Plan Pays 80% after Deductible
Voluntary Termination of Pregnancy	Not Covered
Infertility Services	Plan Pays 80% after Deductible
Assisted Reproductive Technologies	Plan Pays 80% after Deductible
<b>Pharmacy:</b>	
	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays
	Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

Rev 08/2012

**Benefit Code / Riders: NEW BENEFIT CODE NEEDED(PROPOSED PLAN) / 012,013,016,035,039,119,124,126,148,355,599,942,K34**

\* Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.

\* Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

\* In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.

\* Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.

**RIDER HOOH**

**PERMANENTLY DISABLED DEPENDENTS COVERAGE RIDER**

**To the Health Alliance Plan  
HMO Subscriber Contract**

This Rider amends the Health Alliance Plan HMO Subscriber Contract to which it is attached as follows:

**Section 2.2 – Dependents** is amended to include the following:

A Permanently Disabled child of the Subscriber or the Subscriber's Spouse who meets all of the following requirements:

1. Is over the age of 26;
2. Is not married;
3. Was Permanently Disabled before reaching the age of 26; and
4. Relies on the Subscriber or the Subscriber's Spouse for more than half of their support, as determined under Section 152 of the Internal Revenue Code, as amended.

Proof of the Permanent Disability, financial dependence, and eligibility for Medicare must be provided within 31 days of enrollment.

**Section 2.3 – Coverage Period for a Dependent Child** is amended to replace the item regarding a permanently disabled dependent with the following:

Coverage for a child who is Your Dependent continues without regard to age if the child is diagnosed as Permanently Disabled before the child reached the age of 26, and the child relies on You for all or most of their support. A Permanently Disabled Dependent is eligible for continued coverage if all of the following apply:

1. The Dependent is the child of the Subscriber or the Subscriber's Spouse;
2. The Dependent is not capable of engaging in self-sustaining employment because of a Permanent Disability. Certain diagnoses, including but not limited to attention deficit disorder or depression, by themselves, are not evidence of Permanent Disability. Learning disabilities, substance abuse, or the inability to "hold a job" alone is not evidence of Permanent Disability. Examples of diagnoses that may constitute a Permanent Disability include Down Syndrome and traumatic brain injury.
3. The Permanent Disability started and was diagnosed before age 26; and

4. The Dependent relies on the Subscriber or the Subscriber's Spouse for more than half of their support, as determined under Section 152 of the Internal Revenue Code, as amended.

You must provide satisfactory proof to Us of Your Dependent's Permanent Disability, financial dependence, and eligibility for Medicare, no later than 31 days after the Dependent attains age 26. After the initial proof of Permanent Disability, You must give Us proof when We ask for it, from time to time, but not more often than once each year.

Coverage for the Permanently Disabled Dependent will end if any of the following events occur:

1. The Dependent is no longer a dependent of You or Your Spouse as determined under Section 152 of the Internal Revenue Code, as amended;
2. The Dependent's Permanent Disability ends;
3. We do not receive proof that the Dependent is Permanently Disabled within 31 days after requesting such information;
4. The Dependent no longer meets Eligibility requirements for any reason other than reaching 26 years of age; or
5. The Dependent is married after reaching 26 years of age.

**If the Permanently Disabled Dependent is enrolled in Medicare, we must be notified of the Medicare coverage in order to coordinate benefits.**

The Definitions section is amended to include the following:

**Permanently Disabled or Permanent Disability** means a person is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months

**Until further notice, all terms, limitations, exclusions, and conditions of the Health Alliance Plan HMO Subscriber Contract remain unchanged except as provided in this Rider.**

**RIDER 009**

**COMPLEMENTARY MEDICARE RIDER  
FOR MEMBERS WITH MEDICARE PARTS A AND B**

**To The Health Alliance Plan  
HMO Subscriber Contract**

This Rider amends the HMO Subscriber Contract and applicable Riders to provide complementary coverage to Members who are entitled to and enrolled in Medicare Parts A and B. This Rider also amends the HMO Subscriber Contract to provide services to Members who have not advised HAP of their entitlement and/or enrollment status in Medicare Parts A and B. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Eligibility** is amended by deleting **Effect of Medicare Eligibility** and replacing it with the following:

For Members entitled to and enrolled in Medicare Parts A and B, these benefits are equal to the level described in the HMO Subscriber Contract and the applicable Riders to complement the basic Medicare Part A and Part B benefits. Members continue to be entitled to all benefits in the HMO Subscriber Contract to the extent that such benefits do not duplicate Medicare benefits.

Members not entitled to or enrolled in Medicare Parts A and B, or who have not advised HAP that they are entitled to and enrolled in Medicare Parts A and B, are not eligible for coverage under this Rider.

All applicable cost sharing that the Member pays for Covered Services, as defined in the HMO Subscriber Contract and Riders shall apply.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

**RIDER 012**

**DURABLE MEDICAL EQUIPMENT, PROSTHETIC &  
ORTHOTIC APPLIANCES RIDER**

**To the Health Alliance Plan  
HMO Subscriber Contract**

This Rider amends the HMO Subscriber Contract to provide coverage for Durable Medical Equipment and/or Prosthetic and Orthotic Appliances. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Services and Benefits** is amended by adding the following:

**"Durable Medical Equipment" ("DME")** is equipment which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally needed by a person in the absence of illness or injury. The equipment must be a covered item as determined by HAP or its designee.

**"Prosthetic Appliance"** is an artificial device which replaces an absent part of the body or which aids the performance of a natural function of the body without replacing a missing part. The appliance must be a covered item as determined by HAP or its designee.

**"Orthotic Appliance"** is an external device intended to correct any defect of form or function to the human body. The appliance must be a covered item as determined by HAP or its designee.

**Durable Medical Equipment ("DME")**

1. All DME must be ordered by an Affiliated Provider and dispensed by an Affiliated DME Provider. Prior authorization is required.
2. Repair of DME is covered for restoration to a serviceable condition.
3. Replacement of DME is covered when:
  - a. Necessitated by irreparable damage not due to misuse, intentional or nonintentional.
  - b. The cost of repairs would exceed the purchase price.
  - c. Due to a change in the size or condition of the patient as determined by HAP or its designee.
4. All DME must be a covered item as determined by HAP or its designee.

**Prosthetic and Orthotic Appliances**

1. All Prosthetic and Orthotic Appliances must be ordered by an Affiliated Provider and dispensed by an Affiliated Provider. Prior authorization is required.
2. Repair of Prosthetic and Orthotic Appliances is covered for restoration to a serviceable condition.
3. Replacement of purchased Prosthetic and Orthotic Appliances is covered when:
  - a. Necessitated by irreparable damage not due to misuse, intentional or nonintentional.
  - b. The cost of repairs would exceed the purchase price.

- c. Due to a change in the size or condition of the patient as determined by HAP or its designee.
4. One pair of prescription lenses and one pair of frames according to HAP guidelines following a cataract operation or to replace the organic lens missing because of congenital absence are covered.
5. All Prosthetic and Orthotic Appliances must be covered items as determined by HAP or its designee.

The Section entitled **Exclusions and Limitations** is amended by deleting the **Medical Devices and Equipment** and replacing it with the following:

#### **Medical Devices and Equipment**

- (1) DME, Prosthetic and Orthotic Appliances and cataract lenses ordered prior to coverage under this Contract, even if delivered after coverage.
- (2) Replacement and repair of any DME or Prosthetic and Orthotic Appliances resulting from intentional or nonintentional misuse.
- (3) Batteries used for any type of DME.
- (4) Comfort and convenience equipment, exercise and hygiene equipment, corrective shoes and supports, dental appliances, experimental or research equipment, and self help devices not medical in nature such as sauna baths and elevators.
- (5) Physician equipment such as sphygmomanometers, stethoscopes, etc.
- (6) Any DME or Prosthetic and Orthotic Appliances ordered while covered but delivered more than 60 days after termination of coverage.
- (7) Eyeglasses (frames and lenses) except lenses following cataract surgery.
- (8) Hearing aids.
- (9) Lost or stolen equipment.
- (10) Home, or vehicle additions, modifications or appliances.
- (11) Cost of equipment and/or devices in excess of the coverage amounts for standard equivalents.
- (12) Disposable medical supplies, such as dressings and support garments.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

RIDER H013

HEARING AID RIDER

To the Health Alliance Plan (HAP)  
HMO Subscriber Contract

This Rider amends the HMO Subscriber Contract to provide coverage for Hearing Aids.

The Section entitled **Services and Benefits** is amended by adding the following:

**Hearing Aids**

**"Hearing Aid"** means an electronic device worn on the person for the purpose of amplifying sound and assisting the physiologic process of hearing.

Covered Services for Hearing Aids include the following:

1. One standard, conventional hearing aid (as defined by HAP) per ear, when Medically Necessary and provided by an Affiliated Provider.
2. Hearing tests for fitting and post-performance evaluation of a Hearing Aid are covered when provided by an audiologist who is an Affiliated Provider.
3. Replacement of Hearing Aids is covered when:
  - i. Necessitated by irreparable damage not due to misuse, intentional or unintentional.
  - ii. The cost of the repairs would exceed the purchase price.
  - iii. Due to a change in size or condition of the patient that an adjustment to the current device cannot accommodate (including increased hearing loss) as determined by HAP's benefit, referral and practice policies.

The Section entitled **Exclusions and Limitations** is amended by deleting (h)(5) from **Medical Devices and Equipment** and replacing it with the following:

- (5) Hearing Aids ordered prior to coverage under this Rider, even if delivered after coverage under this Rider is effective.
- (6) Replacement and repair of a Hearing Aid resulting from misuse, whether intentional or unintentional.
- (7) Batteries and other supplies and accessories used for Hearing Aids.
- (8) The additional cost of an eyeglass type Hearing Aid over the conventional Hearing Aid cost.
- (9) Lost or stolen equipment.
- (10) Disposable Hearing Aids.
- (11) Hearing Aids and related services provided by a non-Affiliated Provider.
- (12) Tinnitus maskers.

The Section entitled **Exclusions and Limitations** is amended by deleting the exclusion regarding hearing aids.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

**RIDER 016**

**SKILLED NURSING FACILITY RIDER  
(730 Days)**

**To the Health Alliance Plan  
HMO Subscriber Contract**

This Rider amends the HMO Subscriber Contract to add coverage for Skilled Nursing Facility care. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Services and Benefits** is amended by adding the following:

**Skilled Nursing Facility**

1. Skilled nursing facility services are provided up to a maximum period of 730 days for skilled nursing care, for each continuous period of confinement or for successive periods separated by less than 60 days, of which not more than 90 days may be for care for mental illness. To be eligible for care for mental illness the confinement must immediately follow a period of acute care for mental illness at an Affiliated Hospital.
2. A new maximum service period will commence only when there has been a lapse of at least 60 days from the last date of discharge to the next date of admission.
3. The 730 day period will be reduced by 2 days for every inpatient hospital day (or successive periods of hospitalization separated by less than 60 days) prior to or during an admission to a Skilled Nursing Facility.

The Section entitled **Exclusion and Limitations** is amended by deleting **Nursing Services** and replacing it with the following:

**Nursing Services**

- (1) Private duty nursing services.
- (2) Residential and basic nursing services provided in a long-term care facility.
- (3) Skilled nursing facility services for tuberculosis of any kind.
- (4) Custodial care.
- (5) Skilled nursing facility services for senile deterioration or mental deficiency or mental retardation.
- (6) Skilled nursing facility services for mental illness, other than for short-term skilled nursing care cases in which prognosis for recovery or improvement is deemed favorable.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

**RIDER 034**

**EMERGENCY SERVICES  
\$50 COPAYMENT RIDER**

**To the Health Alliance Plan  
HMO Subscriber Contract**

This Rider amends the HMO Subscriber Contract to add a \$50 Copayment or 50% of HAP's reimbursement, whichever is less, for Emergency Services. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

The Copayment is \$50 or 50% of HAP's reimbursement, whichever is less, for Emergency Services rendered in an emergency room.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

**RIDER 035**

**HOSPITAL INPATIENT ADMISSION  
\$100 COPAYMENT RIDER**

**To the Health Alliance Plan  
HMO Subscriber Contract**

This Rider amends the HMO Subscriber Contract to add a \$100 Copayment or 50% of HAP's reimbursement, whichever is less, for inpatient hospital admissions. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

The Copayment is \$100 or 50% of HAP's reimbursement, whichever is less, for each inpatient hospital admission regardless of diagnosis.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

**RIDER 039**

**EMERGENCY SERVICES  
\$100 COPAYMENT RIDER**

**To the Health Alliance Plan  
HMO Subscriber Contract**

This Rider amends the HMO Subscriber Contract to add a \$100 Copayment or 50% of HAP's reimbursement, whichever is less, for Emergency Services. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

The Copayment is \$100 or 50% of HAP's reimbursement, whichever is less, for Emergency Services rendered in an emergency room.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.

**RIDER 119**

**URGENT CARE  
\$25 COPAYMENT RIDER**

**To the Health Alliance Plan  
HMO Subscriber Contract**

This Rider amends the HMO Subscriber Contract to add a \$25 Copayment or 50% of the cost of treatment, whichever is less, per visit for Urgent Care Services. The Premium shall be adjusted by an amount set forth in a written notice from HAP to your Group or Remitting Agent.

The Section entitled **Payment of Premiums and Copayments** is amended by adding the following:

The Copayment is \$25 or 50% of the cost of treatment, whichever is less, per visit for Urgent Care Services regardless of the duration of the visits.

Until further notice, all terms, limitations, exclusions, and conditions of the HMO Subscriber Contract remain unchanged except as provided in this Rider.